UNIVERSITY of VIRGINIA HEALTH SYSTEM

UVA HOSPITAL EAST
1215 Lee Street
Charlottesville VA 22908-0816
ROI Notes Report

NEWHOUSE,WILLIAM P III
MRN: 1997425
DOB: 11/3/1972, Sex: M
Adm: 10/16/2007, D/C: 10/21/2007

Op Note signed by at 10/16/07 1554

Author: Bruce D Schirmer	Service: (none)	Author Type: Physician
Filed:	Date of Service: 10/16/07 1330	Note Type: Op Note
Status: Signed	Trans ID: 032325570	Trans Status: Available
Dictation Time: 10/16/07 1330	Trans Time: 10/16/07 1554	Trans Doc Type: OP/Procedure Note

Acct #: 001003669387

ATTENDING: Bruce D Schirmer, M.D.
SURGEON: Bruce D Schirmer, M.D.

PREOPERATIVE DIAGNOSIS: Skin graft densely adherent to multiple loops of small bowel.

POSTOPERATIVE DIAGNOSIS: Skin graft densely adherent to multiple loops of small bowel.

PROCEDURE: Takedown of skin graft off multiple loops of small bowel, significant and difficult enterolysis of intestines, and repair of small bowel enterotomy (44602, 44005-22).

NOTE: A 22-modifier was used for the fact that this intestinal takedown of the skin graft was an exceedingly difficult and time consuming procedure. It took over 90 minutes to take the skin graft off, and dissection was meticulous dissection with sharp scissors or knife to remove the skin graft of the small intestine, and multiple areas of which it was densely adherent, and there was no easy plane to remove it. This required essentially dividing the skin graft, so that the dermis stayed on in small intestine and the epidermis came off. Progress in process of doing this was extraordinarily tedious and difficult.

SURGEONS: Bruce D. Schirmer, MD; and Naren Gupta, MD, PhD.

ANESTHESIA: General orotracheal

CLINICAL NOTE: This is a 34-year-old man who suffered a traumatic gunshot wound to the abdomen more than a decade ago and suffered multiple abdominal visceral injuries including loss of small bowel, and he is currently existing on a length of small bowel that is normally considered quite minimal for absorption. Nevertheless, he has been able to maintain his weight, and he is now many years out from his injury. The injury left him without any anterior abdominal wall because of the combination of trauma and subsequent infection and fascial necrosis. He has about a dinner plate sized abdominal wall incisional hernia with the only thing covering the bowel and the mid portion of this hernia is skin graft. The skin graft

Exhibit B

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Op Note signed by at 10/16/07 1554 (continued)

surface area measures about 12 inches in height by about 8 inches in width, and on physical examination, one can easily see the bowel peristalsing directly on to the skin graft in the mid portion of the abdomen. When Mr. Newhouse stands up, he has a huge protuberance of the small bowel because there is nothing to hold it in place except the skin graft, and it looks as though when he is standing upright, his profile looks like he has a bowling ball attached to his abdominal wall anteriorly. He wishes to have this repaired, and he first saw me and then I referred him to Dr. Drake for consideration of component separation procedure because there simply was no where to hook a mesh underneath the abdominal wall and do the repair and then have anything to cover the mesh with. I felt he was probably not a good candidate therefore for mesh repair. In addition because of the difficulty in taking the small bowel down, there was a significant risk of enterotomy and small bowel injury and therefore it would be impossible to place a mesh at that time anyway. After seeing Dr. Drake, Dr. Drake recommended component separation part, and his intern re-requested me to takedown the small bowel off the skin graft, and I have agreed to do that. Today, we are both here in the operating room, and Dr. Drake has initiated his portion of the operation and has developed planes to begin the repair, and portion of the operation now for us to takedown the skin graft is at hand, and Dr. Gupta and I are doing this operation.

OPERATIVE PROCEDURE: At this point, the skin graft and the area to be excised was well defined. It measured most of the abdominal wall except the upper part of the abdominal wall below the ribs. There was fascia with skin over it, and Dr. Drake and his team will remove that skin and that will be dictated under separate cover. The remainder of the skin over the abdomen was removed by us, and it was essentially done in a very straightforward fashion. We opened into the peritoneal cavity and then where the intestines were not densely adherent, a combination of cautery dissection, or more normally, sharp dissection with scissors was used to takedown the thin adhesions between the bowel and abdominal wall. However, in the mid portion of the skin graft, there was an area several square inches in size that contained multiple loops of small bowel that were densely adherent to the skin graft. In taking these loops of bowel down, we needed to use sharp dissection with the scissor or occasionally with a knife to divide the tissue plane between the bowel and the skin graft. Often times, this tissue plane was difficult, if not impossible, to define. This required that frequently we had to try to cut into the skin graft enough to leave the dermis on the bowel and take the remainder of the skin graft off. At times when we got close to the bowel, we exposed the raw surface of the bowel wall muscle. In taking down all these loops of bowel, this process was continued until all the loops were taken down. There was 1 loop of bowel densely adherent to the right upper quadrant abdominal wall where in taking it down there was definitely an enterotomy made. This

Op Note signed by at 10/16/07 1554 (continued)

enterotomy was repaired in 2 layers with interrupted 3-0 Vicryl sutures for the enterotomy inner layer repair and then interrupted 3-0 silk Lembert suture for the outer repair. The enterotomy size was about 3 mm. In about 2 or 3 other areas, there were seromuscular defects deep enough to be of concern, and we reinforced these with interrupted 3-0 silk Lembert sutures to oversew them. However, there were no other perforations of the bowel.

A total of over 90 minutes were spent in taking down the difficult part of the adhesions, after which we then felt we had the abdominal wall cleared circumferentially adequately for Dr. Drake to proceed. He inspected and agreed. We therefore turned the operation over to him to proceed with separation of components of hernia repair of the abdominal wall and reconstruction. That will be dictated under separate cover. During all portions of the operation, the blood loss was approximately 100 mL. There were no intraoperative complications during our portion of the operation.

I was scrubbed and present for the entire portion of the operation dictated above.

Dictated and Dated by:

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cc: David Drake, M.D.
Box 800376
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Naren Gupta, M.D. Ph.D.

Op Note signed by at 10/16/07 1554 (continued)

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*** End of Report ***

Op Note signed by at 10/17/07 0632

Author: Chris Campbell	Service: (none)	Author Type: (none)
Filed:	Date of Service: 10/16/07 2120	Note Type: Op Note
Status: Signed	Trans ID: 032358056	Trans Status: Available
Dictation Time: 10/16/07 2120	Trans Time: 10/17/07 0632	Trans Doc Type: OP/Procedure Note

Acct #: 001003669387

ATTENDING: David Drake, M.D.
SURGEON: David Drake, M.D.

PREOPERATIVE DIAGNOSES: Large ventral hernia previously repaired with Vicryl mesh and split-thickness autograft.

POSTOPERATIVE DIAGNOSES: Large ventral hernia previously repaired with Vicryl mesh and split-thickness autograft.

PROCEDURE PERFORMED: 1.Multilayer fascial release and bilateral fasciocutaneous flap reconstruction of ventral hernia (component separation technique repair of large ventral hernia of the abdomen)
2. Surgimend reinforcement of anterior abdominal wall for hernia repair.

ANESTHESIA: General endotracheal anesthesia.

CLINICAL HISTORY: The patient is a 34-year-old male who is now 6 years status post a gunshot wound to the abdomen during which time he suffered injuries to the transverse colon, aorta, and inferior vena cava with previous operative repair. The patient subsequently had ostomy takedown, and Vicryl mesh and split-thickness autograft temporizing repair of the ventral hernia. The patient presents to Clinic now with resolution of abdominal inflammation, and the skin graft was no longer densely adherent to the underlying intestines. Risks, benefits, complications, and alternatives of component separation, musculocutaneous flap, reconstruction of ventral hernia were discussed with the patient who is in agreement to

Op Note signed by at 10/17/07 0632 (continued)

proceed. Dr. Bruce Schirmer's operative team also performed excision of the split-thickness autograft with lysis of adhesions from the intestines, which was covered under a separate operative report. Written and verbal consent for operation was obtained preoperatively, as well as diagrams and illustration of operative incision planning, which was confirmed by the patient.

DESCRIPTION OF PROCEDURE: The patient was identified, consent was confirmed, and the patient was taken to the operative suite, where he was placed in a supine position, and all bony prominences were padded, preoperative antibiotics were given, and cardiopulmonary monitoring was initiated followed by general anesthesia. SCDs were applied and Foley was placed. The patient was prepped and draped in the usual sterile manner, and a marking pen was used to mark the border from the skin graft to the intact skin. A 15 blade was used to make the marked elliptical incision completely surrounding the ventral hernia. An electrocautery was used to elevate bilateral adipocutaneous flaps off of the anterior rectus fascia. Of note, the patient had poor quality fascia, however, successful elevation of adipocutaneous flaps was performed beyond the linea semilunaris bilaterally without difficulty. Hemostasis was obtained with electrocautery.

Dr. Schirmer's team then entered the operative suite for excision of his split-thickness autograft from the abdomen with lysis of adhesions and freeing of the fascial margins.

After this was performed, an incision was made with electrocautery through the external oblique muscle to the level of the internal oblique fascia bilaterally. This incision was then taken through the lateral edge of the rectus sheath exposing the rectus muscle. The anterior rectus sheath was then elevated off of the rectus muscle bilaterally, and folded over in an open-book fashion to close the hernia defect. A 0 Prolene horizontal mattress sutures were used to approximate the anterior rectus sheath fascia bilaterally in a pants-over-vest fashion creating a double fascial layer closure without tension. A #1 Novofil running suture was used for the second fascial layer repair. Due to weakness at the mid-fascial level SurgiMend product having been prepared according to manufacturer's recommendation was the applied over the midline. A 2 layer fascia repair and sewn into position with 0 Prolene running suture. Irrigation was performed, hemostasis was confirmed with electrocautery. Through 2 inferior pilot incisions, 10 flat JP drains were introduced, and 2 Marcaine catheters were introduced. The adipocutaneous flaps were then brought to midline having floated the umbilicus within the right adipocutaneous flap. The flaps were then stapled at midline and there was no tension with the closure and the umbilicus appeared viable. Then, 3-0 Vicryl deep dermal

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Op Note signed by at 10/17/07 0632 (continued)

sutures were used to approximate the flaps, followed by staples to close the skin. Then, 3-0 nylon drain stitches were also employed. Xeroform was applied over the incision followed by Primapore dressings. The patient was transferred to recovery stretcher and extubated in the operative suite

The patient was transferred to recovery in stable condition.

Dr. Drake was present for the entire operation.

Dictated and Dated by:

Chris Campbell, M.D.
Resident
Plastic Surgery

I was present for the entire procedure. I have edited this report as appropriate.

Signed and Dated by:
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***** End of Report *****

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Discharge Summaries signed by David Drake, MD at 10/22/07 1124

Author: Damien Lapar, MD
Filed: 04/19/12 1830
Status: Signed
Trans ID: 032556614
Trans Time: 10/22/07 1124

Service: (none)
Date of Service: 10/22/07 1009
Editor: Damien Lapar, MD
Trans Status: Available
Trans Doc Type: Discharge Summary

Author Type: Resident
Note Type: Discharge Summaries

Dictation Time: 10/22/07 1009

Admission: 10/16/2007
Discharge: 10/21/2007
Acct #: 001003669387

Attending Physician: David Drake, M.D.
Referring Physician: Bruce D Schirmer, M.D.

ADMITTING DIAGNOSIS: Large ventral hernia of the abdomen.

DISCHARGE DIAGNOSIS: Large ventral hernia of the abdomen.

PROCEDURE PERFORMED:
1. Multilayer fascial release and bilateral fasciocutaneous flap reconstruction of ventral hernia (component separation technique to repair large ventral hernia of the abdomen).
2. Anterior reinforcement of anterior abdominal wall for hernia repair.

BRIEF HISTORY: Mr. Newhouse is a 34-year-old male who is 6 years status post of a gunshot wound of the abdomen at which time he suffered injuries to transverse colon, aorta, and inferior vena cava with previous operative repair. The patient then had a subsequent ostomy takedown with a vicryl mesh placement and split-thickness skin autograft .The patient presented to Plastic Surgery Clinic for preoperative evaluation of a component separation repair after his abdominal malformation had resolved and when the skin graft was no longer densely adherent to underlying intestines. At this time, the risk, benefits, complications, and alternatives to surgery were discussed with the patient, and his questions were answered. After an appropriate preoperative evaluation and workup, complete verbal and written consent was obtained from the patient for surgery.

HOSPITAL COURSE: The patient presented to the operative holding area of the University of Virginia Medical Center on the morning of October 16, 2007, for a ventral hernia repair with component separation repair. The patient went to operating room and was intubated without difficulty. He tolerated the procedure well, and he was extubated at the end of the case

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Discharge Summaries signed by David Drake, MD at 10/22/07 1124 (continued)

in the operating room without complication. He was subsequently transferred to the recovery room for further postoperative care and resuscitation. After an initial unremarkable postoperative course, the patient was admitted to the inpatient surgery floor for further observation and pain management. The patient arrived to the floor with a PCA pump, a bupivacaine pump to his wound, and a Foley catheter. The patient's pain was initially controlled on a combination of IV pain and PCA medications. He was initially NPO and was slowly advanced to sips of clear fluid, which he tolerated well. On postoperative day #3, the patient had a bowel movement after which his diet was advanced to a advanced to tolerate status. The patient was tolerating regular diet on postoperative day #4, and his pain was more controlled with a combination of oral pain medications and IV analgesics. The patient's PCA pump was discontinued on postoperative day #4. He was noted to have borderline low O2 saturation levels throughout his hospital course, and he was provided incentive spirometer and encouraged to ambulate often with appropriate resolution. Otherwise the patient's hospital course was seemingly unremarkable. The patient was cleared by PT and OT services for discharge, his bupivacaine wound pumps were removed on postoperative day #5, and he was deemed appropriate for discharge from the hospital on the morning of October, 21, 2007.

COMPLICATION: None.

CONDITION ON DISCHARGE: Upon discharge, the patient was afebrile with stable vital signs for more than 48 hours. He was tolerating a regular diet, and his pain was well controlled on a combination of oral pain medications. The patient was ambulating without difficulty. His physical exam was extremely unremarkable, and his operative wounds were healing well without any overt signs or symptoms of infection. The patient was discharged with 2 JP drains and was provided education regarding the care management and recording of JP output.

DISCHARGE DISPOSITION: The patient was discharged to home with appropriate discharge instructions and followup. I spoke with the patient regarding the discharge instructions and answered his questions appropriately. I also spoke with the patient regarding our plan for discharge, and he was in agreement with this plan.

DISCHARGE MEDICATIONS:
1. Percocet (5/325 mg) take 1-2 tablets by mouth every 4-6 hours as needed for pain.
2. Oxycodone 5 mg take 2 tablets by mouth every 4 hours as needed for pain. He may stagger this dose with Percocet.
3. Keflex 500 mg take 1 tablet 4 times a day for 7 days.

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Discharge Summaries signed by David Drake, MD at 10/22/07 1124 (continued)

4. Docusate 100 mg take 1-2 tablet by mouth daily at bedtime if needed for constipation.

DISCHARGE INSTRUCTIONS:

1. He may take ibuprofen, atenolol as an alternative to narcotic pain medication.
2. Do not take Tylenol and Percocet together.
3. Resume previous home diet.
4. Avoid strenuous activity or lifting in excess of 10 pounds until approved by a surgeon to do so.
5. No driving a motor vehicle, operating heavy equipment until cleared by a surgeon to do so.
6. In case of emergency, please call 911 or go to the nearest Emergency Department.
7. It is clinically important to your health and to the health of others not to smoke.
8. Please call your surgeon's office with any problems or questions.
9. Follow up if you have fever, chills, nausea, vomiting, an early pain, abdominal pain, problems with the wound, redness, drainage or bleeding.
10. Stop dressing 48 hours after surgery. Leave it open to air. You may shower after dressing removal.
11. Clean incision with warm soapy water once daily. Rinse well with clear water. Keep open to air.
12. You may shower, let water run over your wound. Generally, pat dry. Do not soak in tap water for 7 days until your wound is closed.
13. Irrigate urinary drain as instructed.
14. Empty, measure, and record drain output as instructed. Bring your output record at your next scheduled clinic visit.
15. Cleanse skin around drain with warm soapy water. Rinse well and gently pat dry. Apply gauze if there is leakage around the drain otherwise keep drain open to air.
16. Follow up with Dr. Drake in Plastic Surgery Clinic on Thursday October 25, 2007. Please call 424-94-2123 to schedule an appointment.

Dictated and Dated by:

Damien J. LaPar, M.D.
Resident
Surgery

Signed and Dated by:

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Discharge Summaries signed by David Drake, MD at 10/22/07 1124 (continued)

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DL/CBY Job: 100118580 D: 10/22/2007 10:09 A T: 10/22/2007 11:24 A

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Revision History

	Date/Time	User	Provider Type	Action
>	04/19/12 1830	Damien Lapar, MD	(none)	Sign

Attribution information within the note text is not available.

*** End of Report ***

Scan on 10/16/2007 0418 (below)